ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

REQUEST FOR CHANGE TO DHS/DMH PROVIDER RECORD
FORM 1 – ADMINISTRATION INFORMATION

Provider Name: _____

FEIN: _____

Changes are effective on: _____

Section 1 – Provider General Information

Section 1A – ***Administrative Office Information***

DO NOT WRITE IN THIS AREA
FOR OFFICIAL DMH USE ONLY

Approve All		
Approved	**Not Approved**	**Notes**

Legal Name:_____

Agency Name:_____

FEIN:_____

NPI:_____

Mailing Address 1:_____

Mailing Address 2:_____

City, State, Zip:_____

Website:_____

Administrative Contact:_____

Contact Phone:_____

Contacts Email:_____

REQUEST FOR CHANGE TO DHS/DMH PROVIDER RECORD - CONTINUED
FORM 1 – ADMINISTRATION INFORMATION

Provider Name: _____

FEIN: _____

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Section 1B – *Primary Contact Persons*

Approve All		
Approved	**Not Approved**	**Notes**

Chief Executive Officer:_____

Phone:_____

Chief Financial Officer:_____

Phone:_____

Chief Medical Officer:_____

Phone:_____

Chief Clinical Officer/Manager:_____

Phone:_____

Information Management Officer:_____

Phone:_____

Billing Manager:_____

Phone:_____

Section 1C – *Owner Information*

Approve All		
Approved	**Not Approved**	**Notes**

Ownership Type: ☐ Public ☐ Private

Status: ☐ For Profit ☐ Not For Profit ☐ Neither
☐ Gov't Program (State/Federal/County/City)

Owner Name:_____

Mailing Address 1:_____

Mailing Address 2:_____

City, State, Zip:_____

REQUEST FOR CHANGE TO DHS/DMH PROVIDER RECORD - CONTINUED
FORM 1 – ADMINISTRATION INFORMATION

Provider Name: _____

FEIN: _____

Section 1D – ***Board of Directors Information***

DO NOT WRITE IN THIS AREA
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Approve All		
Approved	**Not Approved**	**Notes**

Board President:_____

Phone:_____

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DHS/DMH Reviewed by:_____ **Date:_____**

Date Received by Collaborative:_____

Date Data Entry Complete:_____